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ABSTRACT

Home-based intervention services for emotionally disturbed youth are also commonly known as in-home services, family-centered services, family-based services, intensive family services, or family preservation services. They have developed as a way to deal with serious family problems that often result in the removal of a child or adolescent from the home and placement in a more restrictive setting such as a hospital, foster home, detention facility, or residential treatment center. American society has a long tradition of solving family problems by placing troublesome family members in out-of-home care. After documenting deficiencies in the foster-care bureaucracy, the Adoption Assistance and Child Welfare Act of 1980 was passed which requires child welfare agencies to provide services to prevent unnecessary placement. Home-based services are based on the belief that the family is the most powerful social institution and the family should be supported and maintained whenever possible. Home-based programs also emphasize family empowerment. Most home-based programs deliver services on the family's own "turf" which tends to be less intimidating, less threatening, less stigmatizing, and more acceptable. Home-based services have been successful with a wide variety of populations. In the selection of home-based workers, programs generally look for a particular combination of educational background, previous experience, and personal qualities. Although home-based therapy emerged as recently as the 1980s it has already made major contributions to the mental health field. (ABL)

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TREATING EMOTIONALLY DISTURBED YOUTH:
HOME-BASED FAMILY FOCUSED INTERVENTION

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Abstract

Home-based intervention services are also commonly known as in-home services, family-centered services, family-based services, intensive family services, family preservation services and others. They have developed as a way to deal with serious family problems that often result in the removal of a child or adolescent from the home and placement in a more restrictive setting such as a hospital, foster home, detention facility or residential treatment center. This paper will provide a historical perspective for home-based services, define its philosophy and goals, examine its general characteristics, describe the families served and service providers, discuss its major contributions and criticisms, and summarize research findings.

Treating Emotionally Disturbed Youth:
Home-Based Family Focused Interventions

Historical Perspective

American society has a long tradition of solving family problems by placing troublesome family members in out-of-home care. DeToqueville, the French traveler, noted over 150 years ago that Americans were placing unusual emphasis on the creation of institutions such as asylums and reformatories to manage social problems (Tavantzis, Tavantzis, Brown, & Rohrbaush, 1985). In families where parents were abusive or neglectful, or where children were chronically troubled or troublesome, a common response has been to rescue a good child from bad parents, or vice versa, by placing the child in foster care (Tavantzis et al., 1985).

In the 1970's concern increased over the costly and ineffective use of out-of-home placements as a band-aid solution to family problems. The cost for substitute care at times exceeds \$100,000 per year per child (Bryce & Lloyd, 1982). In addition, during placement, a severely emotionally disturbed child may have made gains, but on returning to his natural home, the child's symptoms often recurred. Placement succeeded mainly in training the child to function within an institution and pathologies frequently remained or expanded rather than being ameliorated (Ryan, 1979).

After documenting deficiencies in the foster-care bureaucracy, Congress passed the Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272). The Act requires that child welfare agencies provide services to prevent unnecessary placement and that, in each case, a court must determine that the state agency has made reasonable efforts to prevent or eliminate the need for alternative placement (Ratterman, 1986). Legislation in many states has provided further impetus to develop home-based services to help children remain at home with their families. As a result, there is a clear trend toward the development of home-based services within the child welfare system.

Within the mental health system, calls for reform have focused on the need for comprehensive "systems of care" for emotionally disturbed children (Stroul & Friedman, 1986). As noted by Heying (1985), there have been a limited number of options for treating severely emotionally disturbed children and adolescents. Services

are often limited to either one hour of out-patient care per week or long-term institutional care. Home-based services represent a needed alternative to these two extremes by providing intensive, family-focused services which could reduce the need for residential placement. Thus, home-based service programs are beginning to develop to serve families of emotionally disturbed children (Stroul, 1988).

Philosophy and Goals

Home-based services are based on the belief that the family is the most powerful social institution and the family should be supported and maintained whenever possible. The importance of the family unit is the basis for home-based services and represents the core philosophy of these programs. Home-based programs reflect the principle that the first investment should be made in the care and treatment of children and families in their own homes (Stroul, 1988). Society should invest as much effort and money in working with a child's own family to prevent placement as it invests in out-of-home foster care.

Home-based programs also emphasize family empowerment. They promote the idea that parents are in charge of their families and home-based services are provided to support, encourage and assist them in the parenting role. Home-based services attempt to recognize, respect and build upon the inherent strengths of the family (Leverington & Wulff).

The perspective of home-based service programs can best be described as an ecological systems orientation (Stroul, 1988).

This approach attempts to include all involved persons and agencies in the service delivery process. The emphasis is on "networking" with all agencies and professionals that affect the family (Aponte, 1987). Minuchin (1970) warns that if we fail to take into account the family's ecological system, family problems and pathology will continue to be seen as arising from within the family unit. The theoretical framework underlying the home-based family-centered treatment program is systems theory (Zarski & Zygmund, 1989). Within this theoretical framework the family is perceived as the primary system of care. Utilization of a systems framework allows home-based family therapists to examine the complex relationship patterns between the family unit and the other social systems (e.g., the schools, work place, social service agencies, neighborhoods, etc.) that maintain the ongoing problems (Zarski & Zygmund, 1989).

Most home-based service programs strive to achieve three primary goals: 1) To preserve the integrity of the family unit and to prevent unnecessary out-of-home placement. 2) To link the family with appropriate community agencies and individuals to create an ongoing community support system. 3) To strengthen the family's coping skills and capacity to function effectively in its own community (Stroul, 1988). In addition to intervening to prevent out-of-home placements, many home-based programs are used to assist children already in placements to reunify with their families.

Characteristics

Most home-based programs share similar characteristics. The major feature is that the intervention is delivered primarily in the family's home (Bryce, 1979). Services delivered on the family's own "turf" tend to be less intimidating, less threatening, less stigmatizing and more acceptable (Hinckley & Ellis, 1985). Assessment and progress is more accurate when based upon direct observation of the family in their own environment. Families can practice in their homes where they will need to use the skills, with the therapist present to model, and provide feedback (Stroul, 1988). More often than not, parents are anxious to have professionals in the home in order to show their own and their child's "worst side". It is as if they wish to prove the existence of their problems and thereby justify their need for help (Behrens & Ackerman, 1956).

The hours of service delivery are flexible in order to meet the needs of the families. They are generally provided at times that are convenient to the family including evenings and weekends. Frequency and length of sessions are determined by the needs of the child or adolescent and family. Nearly all home-based programs offer 24-hour crisis intervention to the families. They know that help and support are available if a crisis arises (Stroul, 1988).

Home-based services are multifaceted. They may include therapy, skills training and case management services to obtain and coordinate necessary resources and supports. The program will help or arrange for help with any problem area presented by the family

or observed to be a problem by the home-based service providers. (Bryce, 1979).

Home-based services are offered along a continuum of care based upon the goals of the program and the target population served. The most significant variables along this continuum are service intensity and duration. The short-term crisis intervention model was pioneered by Homebuilders of Tacoma, Washington in the 1970's. They provide highly intensive services, up to 20 hours per week, for approximately four to six weeks. They focus on crisis stabilization while linking the family with other services and supports to meet their longer-term needs (Stroul, 1988).

On the opposite end of the continuum are programs which provide services for longer durations of time. Kaleidoscope in Chicago, Illinois is not a time-limited program and works with families an average of 18 months. The value of a long-term, continuous, supportive relationship with a single provider is particularly useful for severely dysfunctional, multiproblem families. Many families have longstanding, multiple problems which require intensive and long-term efforts in order to improve. They have had negative experiences with a series of providers and need a longer time to build trust in an effective counseling relationship. These programs extend their focus and goals beyond the crisis and continue family work on an ongoing outreach basis (Stroul, 1988).

Home-based workers are usually assigned to work with small caseloads. This permits them to be actively and intensively

involved with each family. Caseloads generally vary from two families per worker to caseloads as high as 12 families. Small caseloads contribute to the uniquely close, intense and personal relationship that develops between the worker and the family. To overcome the "professional distance barrier" the workers generally dress and behave in a relaxed, casual manner and interact with the family under informal circumstances such as around the kitchen table (Stroul, 1988). Often improved trust and motivation are experienced because of this unique relationship.

Families

Home-based programs also share similar acceptance criteria. In order to be considered for home-based the following criteria need to be met: 1) The family must reside within the geographic area served by the program, generally a specific county. 2) The child must be in imminent risk of out-of-home placement. 3) At least one parent must be willing to be involved with the programs and work toward keeping the family together. 4) There is no serious threat of physical danger to staff. 5) Less intensive services are not sufficient to meet the family's needs (Stroul, 1988).

Home-based services have been successful with a wide variety of populations. Lloyd and Bryce (1984) outline the types of families for whom home-based services may be most effective. These are families of adolescents in conflict with their family and community such as acting out adolescents and status offenders, families at risk of child abuse or neglect, families of emotionally

disturbed children and families of children with developmental disabilities. Home-based programs are also ideally suited to work with minority families. Because the workers are present in the home and in the neighborhood they are able to easily observe and understand differences in culture, lifestyle and values.

Staff

In the selection of home-based workers, programs generally look for a particular combination of educational background, previous experience, and personal qualities. The educational background varies across programs with most staff at either the Bachelor's or Master's level. Experience may include crisis intervention, family therapy, protective services or case management. A heavy emphasis is placed on personal qualities including social skills, commitment, enthusiasm, acceptance of others, flexibility, maturity and a good sense of humor (Stroul, 1988). Home-based programs use a wide array of professionals and paraprofessionals in a variety of configurations and roles. Some programs utilize staff individually to work with families while others use a team approach.

An essential added ingredient to these programs is training and supervision for the home-based therapist. At this time little has been published about training therapists to do this difficult job. One training model consisted of five 2-day workshops which covered the following areas: (a) Family-as-a-System; (b) Structural Family Therapy; (c) Family Crisis Intervention; (d) Family Assessment; and (e) Family Simulation (Zarski, Pastore, Way

& Shepler, 1988). A supervision model was developed by Zarski and Zygmund (1989) to utilize the positive aspects inherent in a family focus approach and to facilitate therapist growth through a variety of supervisory interventions. This supervision model is based on Liddle and Saba's principle of isomorphism in therapy and training and Stoltenberg's work on therapist development. This model has proved highly effective for training novice therapists working with multi-problem families.

Contributions and Criticisms

Home-based therapy emerged as recently as the 1980's. Although it is still in its infancy stage, it has already made major contributions to the mental health field. Home-based therapy can be credited with underscoring the importance of the natural family because it maintains the goal of family preservation and reunification. Second, therapists are available on a 24-hour-a-day basis, work flexible hours, and schedule sessions on the basis of family and therapist need so that therapy time is optimal (Zarski, et al., 1988). Third, the relationship between the home-based worker and the family is uniquely intense and personal and can overcome professional and cultural barriers. Fourth, home-based programs focus on the entire family in order to build on family strengths and empower families. Fifth, home visits are less threatening, less stigmatizing and provide a realistic setting for learning and practicing new skills. Sixth, home-based services are more cost-effective than out-of-home placements. Seventh, home-based treatment is highly effective. Both national and local

programs report significant success in keeping the youth and family together. Ohio has reported success rates as high as 90% (Stroul, 1988).

A number of criticisms related to the development and delivery of home-based services also have been identified. Programs struggle to define the optimal mix of service intensity and duration for the program as a whole and for each individual family. Second, by working in the family's home, workers may be placed in jeopardy. It is difficult to expect them to cope with potentially threatening and dangerous situations and at the same time conduct therapy. Third, home-based services may be seen as intrusive because they are delivered in the home and are very intense. Fourth, it is easy for home-based workers to become enmeshed in the family system thereby exacerbating the problems. Workers may become simply another stabilizing force who remains with family members as they go through repeated crises (Kagan & Schlosberg, 1989). Fifth, the families may become overly dependent on the worker and then less likely to survive on their own. Sixth, statistics showing between 70-90% success rates should be interpreted cautiously. It has not yet been determined that once home-based services are withdrawn the families continue to do well.

Research

In September, 1989, the Bellefaire/Jewish Children's Bureau, the Mandel School of Applied Social Sciences at Case Western Reserve University, and the Treu-Mart Fund co-sponsored a two-day national conference on home-based research. The conference was

designed to identify the major conclusions that can be drawn from research, to assess the status of existing research, and to list specific recommendations for future research.

Three major conclusions from research can be drawn from the conference proceedings. 1) There is a consensus that programs do prevent the placement of some portion of children served. 2) These programs are less costly than are placement services. 3.) There is evidence that children who are older and who exhibit anti-social behavior or who have been multiply-placed are less likely to remain at home than younger children who have never been placed.

Results from the conference show a number of significant limitations with home-based research designs. Few studies use comparison or control groups; the flow of families through programs is poorly described; data-collection procedures are not articulated; the reliability of measures is not addressed; assessment of change relies upon single variable analyses; and problems posed by statistical regression effects are not taken into account. There are also numerous problems associated with the use of placement rates as the indicator of outcomes. 1) It is not clear that all children who received services would have been placed without the services. 2) Placement rates are difficult to evaluate because they depend upon the amount of resources available in a community. 3) There are few assessments of how children and families are functioning at termination.

The conference also suggested recommendations for future research in eight areas. 1) Investigations are needed to determine

what portion of the population approved for out-of-home placement meet the criteria for entrance into home-based services. 2) Outcome evaluations based upon experimental designs are needed to assess the degree to which home-based services are meeting their goals. 3) Longitudinal evaluations are needed to assess whether the outcomes that are achieved are maintained over time. 4) Investigations are needed to assess the impact of the ecological context in which programs are operating. 5) Process evaluations are needed to examine the clinical assumptions underlying models and the ways in which clinicians and their families experience programs. 6) Comprehensive evaluations of the functioning of families at service termination are needed. 7) Investigations of the cost of services which take into account all services used by families during and after home-based services. 8) Investigations of the barriers to, and facilitators of, replication of services in varying contexts (Wells & Biegel, 1990).

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